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Politics of Birth Places: Examining the Ethics of Birth Place Choices

SUMMARY

This work examines the ethical aspects of restricting homebirth. It focuses on how restricting homebirth can breach the principle of autonomy because pregnant citizens¹ not only risk losing control over the medical decisions facing them, but also autonomy over their actions and control over their bodies. Using Berlin's discussion on freedom, this work discusses the rather hidden oppressive nature of birth restrictions that appears when it is framed as helping pregnant individuals choose a moral option as per the advice of medical authorities at the expense of seeing an institutional failure to provide informed choice or options for birthing places for their so-called "best interest". Three main arguments are offered why restricting homebirth can potentially violate autonomy: (1) imposing the authority to decide on the maternal body issues; (2) imposing standards on motherhood and pregnancy; and (3) imposing how to ascribe value to risk. These arguments highlight how the state and medical institutions have established authorities in the birthing process to justify restricting homebirth. When the state and medical institutions are framed as the moral authority for birth places, contrasting preferences of pregnant individuals are bound to be judged with guilt-ridden sentiments, shame and other value-laden labels related to one's choice rather than be seen as a reflection of the quality of institutional support. Homebirth restriction reflects that a pregnant person's decision of birthplace is not isolated from the availability of one's choice. Indeed, there is an ethical interest in restricting homebirth, as this could be benevolent at best and discriminatory at worst.

Keywords: homebirth, moralization, freedom.

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1 For the purposes of this study, the terms "pregnant persons/individuals/citizens" refer to anyone capable of pregnancy regardless of any technological intervention such as sexual-reassignment surgery or hormonal modifications.

Introduction

The practice of homebirth gained traction in the mid-1900s, which promoted out-of-hospital births to celebrate the liberal ideals of self-determination and autonomy². From the medical perspective, advocates of home births argue that the choice of home birth has been argued to be as safe as facility-based delivery³. Zielinski *et al.*⁴ also report that those intending to give birth at home are less likely to suffer obstetric interventions. From a social standpoint, home birth allows for more autonomy or the “expansion of capacity of making choices”⁵ exercised by the pregnant human at the time of childbirth. The choice of homebirth has also been a tool for an active rejection of hospital-based birth due to “loss of control” to the birthing process⁶. Most of those who delivered at home felt comfort in the informal setting with a midwife, especially those who experienced discomfort in repeated exams during hospital-based birth⁷.

On the contrary, at the beginning of the 21st century, hospital-based deliveries have increased in all regions in the world for the purpose of reducing maternal and neonatal mortality rates⁸. As such, some states oblige child-bearers to give birth in medical facilities. The primary reason to ban homebirth is to avoid medical risks and protection of the public against medical frauds; however, this has not been practiced all over the world⁹. For instance, whereas Hungary ban midwives and other non-licensed birthing assistance with imprisonment as punishment¹⁰, the UK offers a range of options for maternity care, including home, hospital, and birth centers, as well as the type of provider between midwife or physician¹¹. Developing countries also

2 For example, Haire, D. (1972); Morgan, K. (1998); Nichols, F. (2000); Tuana, T. (2006).

3 Pilley, E. N. (2005) *Birthing Autonomy: Women's experiences of planning home births*. London: Routledge.

4 Zielinski, R., Ackerson, R., Low, R. K. (2015), Planned home birth: benefits, risks, and opportunities, *International Journal of Women's Health*, 7, 362.

5 Sanfelice, C. F. O., and Shimo, A. K. K. (2015), Social representations on home birth, *Escola Anna Nery Revista de Enfermagem*, 19(4), 610.

6 Singh, M. (2015), Bioethics of Home Birth, *The Perinatal Gazette*, 15(1), 1-2.

7 Howe, E.G. (2013), When a mother wants to deliver with a midwife at home, *Journal of Clinical Ethics*, 24(3), 172.

8 Montagu, D., Sudhinaraset, M., Diamond-Smith, N., Campbell, O., Gabrysch, S., Freedman, L., Kruk, M. E. & Donnay, F. (2017), Where women go to deliver: understanding the changing landscape of childbirth in Africa and Asia, *Health Policy and Planning*, 32(8), 1146.

9 Romanzi, L. (2014), Natural Childbirth – a Global Perspective, *American Medical Association Journal of Ethics* 16(10), 835; Zielinski, R. *et al.* (2015).

10 Hill, A. (2010), Hungary: Midwife Agnes Gereb taken to court for championing home births, *The Guardian*, <https://www.theguardian.com/world/2010/oct/22/hungary-midwife-agnes-gereb-home-birth> (accessed: 10 January 2020).

11 National Institute for Health and Care Excellence (2014). Intrapartum care: care of healthy women and their babies during childbirth. *NICE clinical guideline*, 190, <https://www.nice.org.uk/guidance/cg190> (accessed: 20 January 2020).

have differences in terms of policies for birthing. In the Philippines, some cities have ordinances that prohibit deliveries at home. Most prominent is the No Homebirth Policy in the Quezon City, in which there is a fee involved if the parties, pregnant person and provider, violate the policy¹². Likewise, in the early 2000s, Malawi and Rwanda imposed regulations that discourage home deliveries as both countries have improved access to birthing facilities¹³. In India, most people giving birth in facilities are part of the national conditional cash transfer program in 2005¹⁴.

However, if regulating home birth is to be assessed based on the assumption that home birth is less safe, the evidence is mixed, at best. Studies have shown that “the same protective effect of facility delivery found in OECD countries is not apparent in low- and middle-income countries”¹⁵. For low- and middle-income countries, the results are difficult to generalize. In some countries, such as Malawi, maternal and neonatal deaths decreased in hospital-based deliveries, but the same cannot be said for other countries, such as Ethiopia, despite the improvement in access to care and improved access to referral systems¹⁶. Also, in India, despite the advancement in access to facilities, maternal and neonatal mortality rates are still high¹⁷. Given the difference in evidence either way, the intensity and polarity of the positions taken about homebirth open a space for debate, at least, in the level of how ethics should be applied.

Aside from risk-related outcomes, however, there are important ethical considerations regarding home birth restriction that cannot be simply drawn from empirical evidence. Such regulation also raises important questions on whether it is ethical and legally defensible, and whether certain practical challenges to its implementation could be overcome. Advocates, scholars, and medical practitioners themselves have

12 Santos, A. (2013), Are home births being banned? *Rappler*, <https://www.rappler.com/move-ph/30016-are-home-births-being-banned> (accessed: 01 February 2020); Santos, A. (2016), [Dash of SAS] Forbidding and punishing home births *Rappler*, <https://www.rappler.com/views/imho/118079-dash-sas-forbidding-punishing-home-births> (accessed: 01 February 2020).

13 Montagu, D. *et al.* (2017); Cammack, D. (2011), Local governance and public goods in Malawi. *IDS Bulletin* 42, 43; Bucagu, M., Kagubare, J.M., Basinga P., Ngabo, F., Timmons, B. K., and Lee, A. C. (2012), Impact of health systems strengthening on coverage of maternal health services in Rwanda, 2000–2010: a systematic review. *Reproductive Health Matters* 20(39), 50.

14 Lim, S.S., Dandona, L., Hoisington, J.A., James, S.L., Hogan, M.C., and Gakidou, E. (2010), India's Janani Suraksha Yojana, a conditional cash transfer program to increase births in health facilities: an impact evaluation, *The Lancet*, 375, 2009.

15 Montagu, D. *et al.* (2017).

16 Pitchforth, E., Lilford, R., Kebede, Y. Asres, G., Stanford, C. & Frost, J. (2010), Assessing and understanding quality of care in a labour ward: a pilot study combining clinical and social science perspectives in Gondar, Ethiopia, *Social Science and Medicine*, 71, 1740.

17 Randive, B., Diwan, V., and De Costa, A. (2013), India's conditional cash transfer program (the JSY) to Promote Institutional Birth: is there an association between institutional birth proportion and maternal mortality?, *PLoS ONE* 8, e67452.

expressed their positions against court-ordered delivery methods along with other mandatory prenatal treatments. For instance, The American College of Obstetricians and Gynecologists¹⁸ states that “[p]regnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life”. Pertinent to this issue is whether or not institutions may impose limits on the freedom of pregnant individuals in terms of the birthplace they choose for delivery. Thus, for those who are pro-homebirth, deliveries can be best controlled through awareness and information dissemination and completely unsuited to any much more serious social sanctions. Another paradigm, however, is that the birthing process is something that requires formal codes for irreversible consequences such as mortality. Thus, the homebirth restriction is not only acceptable but also can have moral grounds to be obliged. This opens up ethical discussions for states with regard to restricting citizens’ freedom on the one hand and granting freedom of choice, on the other. As such, this work does not address the issue of whether or not births must be done in hospitals alone. What this article takes into the discussion is the ethical issue around banning home birth.

Bioethical Issues of Home Births

Homebirth opens up discussions on the ethical principle of autonomy¹⁹, which is important in medical ethics. Autonomy or self-rule can be described as “free[dom] from both controlling interference by others and from certain limitations such as an inadequate understanding that prevents meaningful choice”²⁰. This primarily involves making one’s own decisions in so far as it is compatible with equal recognition for the autonomy of others. In medical ethics, this requires consulting and obtaining agreement before undergoing any medical procedure²¹. In claiming autonomy, one can argue that giving birth is a private decision over one’s body, harming only the pregnant individuals themselves. In this paradigm, home birth restriction infringes on pregnant citizens’ privacy over their bodies. Central to these arguments is the perspective that the right to choose home birth is an inherent human right. However, this is challenged by evidence of unnecessary deaths and the potential to influence other people to have a homebirth. Thus, autonomy should be superseded by the state.

18 The American College of Obstetricians and Gynecologists’ Committee (2016), *Committee Opinion*, 664, 1.

19 Singh (2015).

20 Beauchamp, T. L., and Childress, J. F. (2009), *Principles of biomedical ethics* (6th ed.). New York; Oxford University Press, 99.

21 Ibid.

This matter can be referred back to the complexity of the concept of autonomy. In this work, respecting autonomy means respecting pregnant people's freedom to decide for themselves, the difference in the notions of freedom becomes important. The crucial situations bioethics often falls within are related to the question of whether or not a pregnant individual is free to decide to have homebirth in risky situations that may cause maternal mortality. In bioethical discussions, a patient's autonomy is to be respected as long as the choice was made rationally²². Some would point out that granted autonomy must be rooted in the guiding principles of a community²³.

Berlin²⁴ argues that freedom of choice is central to the concept of autonomy and that this idea should inform thinking about the tensions in deciding whether or not it is an act that respects autonomy. The concept of freedom is constructed as contrary to that of oppression. Taking freedom of choice as its basis, the notions of positive freedom and negative freedom surface. The former refers to a freedom from interference, and the latter is about having the agency to control one's self with the ability of "conceiving goals and policies of [one's] own and realizing them"²⁵. And indeed, statutory laws require citizens to follow given standards designed to help them coexist peacefully and function well as citizens. These restrictions yield other benefits, such as efficiency, security, and prosperity. The main question is whether the freedom to choose birthplace serves as protection against the control of the state over bodies or that the state is there to protect pregnant citizens against undesirable choices they can potentially make themselves. Berlin expresses a concern that the idea of restricting freedom for the "greater good" or the citizens' "best interest" can be lopsided and coercive as imposed by a government even in a democratic context, such that individuals are made to think that they still keep their own freedom when they could be unwittingly coerced by any external system. While it is a normative practice to restrict freedom to avoid conflict between and among freedoms, it carries the implication that individuals are passive and docile subjects, unable to decide for themselves and their "best interest". This is especially pertinent to the areas of life that are debatable in terms of regulatory practices, and the extent to which individuals should have freedom. The following sections discuss three main points on how homebirth restriction can infringe freedom rather than facilitate it.

22 Gillon, R. (1985), *Philosophical medical ethics*. Chichester; John Wiley and Sons, 69; Burycka, J. F. (2001). Assessing the ethical weight of cultural, religious and spiritual claims in the clinical context, *Journal of Medical Ethics* 27, 120.

23 Engelhardt, H.T. (2011), The many faces of autonomy, *Health Care Analysis*, 9, 293.

24 Berlin, I. (1969), Two Concepts of Liberty In I. Berlin (ed.), *Four Essays on Liberty*, Oxford; Oxford University Press, 118.

25 Ibid, 131.

Homebirth Restriction against Freedom

For all its appeal, implementing the homebirth restriction steers the curtailment of freedom, because not only do pregnant individuals risk losing control over the medical decisions they face, but also the moral autonomy over their actions and control of the emotions they associate with their decisions. There is an important kind of nuance in considering the “best interest” of pregnant citizens, for it can place a moral burden on pregnant citizens to choose what the state imposes as their “best interest”. Since authorities set normative standards to maternal health, the choice of birth place is framed under a moral discourse, rather than a political one. Framing maternal health into a moral discourse has some implications on how citizens experience freedom. Restricting homebirth falls short not for any inherent emotional harm but also for its potential to condemn pregnant persons as having immoral choice. To interpret homebirth restriction as facilitating the “best interest” of pregnant citizens and, to some extent, of the newborn is to presuppose a population that is bound to choose an evil option without taking into consideration what alternatives are possible. There are three ways in which homebirth restriction subtly curtails political freedom in the process of birth.

1. Imposing on the authority to decide on the maternal body issues—One argument for banning homebirth is that the state is actually doing pregnant citizens a favor, that is, conferring upon them a health benefit by hindering them from doing a risky activity. The risk argument might establish a presumptive priority of the state and medical practitioners to take over the right to choose from pregnant citizens because pregnant individuals are exposing themselves to unnecessary risks. Moreover, given that two parties participate in homebirth, non-physician birth providers, such as midwives, are also banned from offering their services on the grounds that the state is preventing them from contributing to the risk to pregnant citizens in the same way that we can prevent cigarette manufacturers from producing too many cigarettes. Not only are pregnant individuals restricted in choosing the birth place, they are also often forced to undergo a Caesarean section in hospitals instead of vaginal delivery at home²⁶.

A different kind of moral interpretation is, of course, possible. Berlin argues that leading people to believe that they are still keeping their freedom when there is justified coercion involved may be ethically problematic. Is it morally acceptable for the state to argue that it is legitimate to coerce pregnant persons to refuse homebirths for their “own good”? For instance, homebirth restriction situates itself against the “alternative” or traditional ways of giving birth, which also differentiates “skilled”

26 D’Ambruoso, L., Abbey, M., and Hussein, J. (2005), Please understand when I cry out in pain: women’s accounts of maternity services during labour and delivery in Ghana, *BMC Public Health*, 5(1), 140.

from “unskilled” birth attendants. Granted that these categories are formulated with “good faith”, such categories put pregnant individuals under certain expectations wherein those who abide by the policy are associated with being “less problematic”²⁷, while those who choose the “alternative” way are seen negatively²⁸. To choose midwives as birth attendants means to choose “nomadic” ways of birthing²⁹.

However, following Berlin’s arguments, human decisions are value judgments about what individuals perceive as valuable to them in their current situations. And in these discretions, neither the state nor medical community holds any special expertise. This technocratic treatment hurts the freedom of the pregnant person in the sense that choices are already value-laden and “[a]ny deviation from an existing prevalent construct [of pregnancy and birthing process] is therefore treated as excessive and condemned by society”³⁰. This neglects that pregnancy is socially constructed (ibid), which makes some practices normalized, and everything else is invalidated. That “everything else”, however, can be broken down to “has been proven harmful” and “has not been proven safe” birthing practices. And what “has not been proven safe (yet)” belongs to a spectrum of probability, ranging from “entirely improbable” to “highly probable” to be safe, based on careful research. To be sure, anything that has not been positively proven as safe is still subject to changes and should be kept open for testing, rather than dismissed. As Dworkin³¹ also argues, a person “cannot rightfully be compelled to do or forbear because it will be better for him [her] to do so, because it will make him [her] happier, because, in the opinion of others, to do so would be wise, or even right.”

Framing homebirth restriction as something that caters to the ‘best interest’ of pregnant citizens raises doubts about whether there is indeed freedom. The pregnant citizens cannot be assumed to make blind decision as they may ascribe different values to risks and to their bodies. As Berlin states, “[i]t is one thing to say that I may be coerced for my own good which I am too blind to see It is another to say that if it is my good, then I am not being coerced, for I have willed it, whether I know this or not”³². This also assumes that pregnant citizens act only as docile citizens rather than active citizens capable of reflecting on their best interests. This analysis

27 Drglin, 2007 cited in Prosen, M. and Krajnc, M. T. (2013), Sociological Conceptualization of the Medicalization of Pregnancy and Childbirth: The Implications in Slovenia, *Revija za Sociologiju*, 43(3), 251-272.

28 Brubaker, S. J. and Dillaway, H. E. (2009), Medicalization, Natural Childbirth and Birthing Experiences, *Sociology Compass*, 3 (1), 31.

29 Walsh, D. (2007), A birth centre’s encounters with discourses of childbirth: How resistance led to innovation, *Sociology of Health & Illness*, 29 (2), 216.

30 Prosen and Krajnc (2013), 268.

31 Dworkin, G. (1972), Paternalism. *Monist*, 56 (1), 64-84. Reprinted in Sartorius, ed., 1983, 64.

32 Berlin (1969), 134.

misses the reactive character of stakeholders—that there are contested rationalities underpinning homebirth restriction. It also misses the consultative character of democratic politics—that stakeholders are not just producers of rhetoric, but are also responding to the pragmatic demands of their constituencies.

Using the “best interest” argument to justify statutory restrictions to homebirth not only potentially curtails freedom, but also implements coercion to give birth in state-approved places. This subtle coercion under the veils of “best interest” is further condoned and camouflaged by the professionalized framing of the birthing process. One of the most technocratic justifications of experts on birth and childbearing is drawing distinctions between “complicated” and “normal” pregnancies³³ due to differences in hazards to birth outcomes. For instance, experts maintain that unwanted pregnancies result from undesirable sexual practices such as mistimed and unplanned sexual activities³⁴. In this case, authorities set normative standards for different activities, from sexual practices to pregnancy. However, patients are not the only ones affected by the power vested in medical institutions. Even physicians acquire “defensive medicine” in homebirth, that is, refusing to perform home deliveries failure to hospitalize could be considered as *de facto* negligence³⁵.

Obviously, it does not follow that the “best interest” cannot be used as a justification for controlling freedom. Johnson³⁶ argues that there are different understandings of pregnancy and childbirth, and restraining in contemporary medical literature fails to acknowledge socio-cultural dimensions important to pregnant individuals³⁷. Indeed, some pregnant citizens might need aid to be aware and comprehend their “best interests” fully and achieve their full potential, and the state has that moral obligation to help them do so. This is what justifies arguments against assisted suicide. It is a moral discussion that states do not allow assisted suicide limiting freedom to end one’s life because of the belief that it is in the citizens’ own “best interests” not to die by choice. To leave suicidal people free to do whatever they like, would, arguably, amount to the neglect of a moral duty to protect citizens from harm, albeit self-harm. In the case of pregnant persons, it is also arguable that the state has a moral duty to help them have a safe and satisfying birthing experience.

33 Conway, K.S. and Deb, P. (2005), Is Prenatal Care Really Ineffective? Or, Is the ‘Devil’ in the Distribution?, *Journal of Health Economics*, 24(3), 489–513.

34 Govindasamy, P., Stewart, M. K., Rustein, S. O., Boerma, J. T. and Sommerfelt, A. E. (1993), High-risk births and maternity care, *DHS Comparative Studies No. 8*, Maryland, USA: Macro International Inc.

35 Annas, G. J. (1978), Law and the Life Sciences: Homebirth: Autonomy vs. Safety, *The Hastings Center Report*, 8(4), 19.

36 Johnson, C. (2008), The Political “Nature” of Pregnancy and Childbirth, *Canadian Journal of Political Science*, 41(4), 889.

37 Belousova, E. (2010), The preservation of National Childbirth traditions in the Russian homebirth community, *Folklorica* 7, 7.

2. *Imposing standards on motherhood and pregnancy*—Pregnancy has always been subjected to some social control, which can be traced from the moralizing roots imposed on the maternal body³⁸. The term ‘pregnant’ is not only a biological condition but also a form of social identity, shaped by time and place³⁹. Moreover, expectations on the maternal body are as entrenched as ever in training pregnant people to act in certain ways, and in glamorizing “motherhood” as a life goal⁴⁰. For instance, Douglas and Michaels (2004) point out that there is a dominant ideology of motherhood, one that is wholly child-centered, emotionally involving, time-consuming, and labor-intensive or what Vincent⁴¹ calls “intensive mothering”. DiQuinzio⁴² also observes that the prevalence of what she calls “essential motherhood” that places motherhood an identity for which pregnant individuals are being valued. However, motherhood is a rather complex role and a social construction rather than a fixed identity⁴³.

Several authors also point out that facility-based births impose that the obstetric and gynecological institutions assume “dominance over the birthing process”⁴⁴. For instance, in *The Impossibility of Motherhood*, DiQuinzio⁴⁵ argues that motherhood is a heavily contested concept and there are different ways to live up this role from pregnancy and beyond. As such, maternal delivery has been endowed by the ideals set by the medical community, thus, in turn, pathologizing the maternal body, pregnancy, and the birthing process⁴⁶. Feminist scholars, such as Shulamith Firestone⁴⁷, even contend that pregnancy is unnecessarily domesticized. At the end of the 20th century, the maternal body was interrogated and acquitted of “slavery”⁴⁸. While the non-Western world had a different transition to the expectations in

38 Johnson, C. (2008).

39 Graham, H. (1976), The Social Image Of Pregnancy: Pregnancy As Spirit Possession, *Sociological Review*, 24(2), 291.

40 Oakley, A. (1980), *Women Confined: Towards A Sociology Of Childbirth*. Oxford: Martin Robertson.

41 Vincent, C. (2010), The sociology of mothering, in: M. W. Apple, S. Ball, L. A. Gandin eds., *The Routledge International Handbook of the Sociology of Education*, London; Routledge, 109-120.

42 DiQuinzio, P. (1999), *The impossibility of motherhood: Feminism, individualism and the problem of mothering*, New York, NY; Routledge.

43 Nakano, G., E. (1993). Social constructions of mothering: A thematic overview, in: E. N. Glenn, G. Chang, and L. Rennie Forcey eds., *Mothering: Ideology, experience, and agency*, London; Routledge, 3–5.

44 Matthews, J. J., and Zadak, K. (1991), The alternative birth movement in the United States: History and current status, *Women and Health*, 17, 39–56.

45 DiQuinzio (1999), 6.

46 Nichols, F. (2000), History of the women’s health movement in the 20th century, *Journal of Obstetric, Gynecological, and Neonatal Nursing*, 29, 56–64; Block, J. (2012), How to scare women, *Slate Magazine*, http://www.slate.com/articles/double_x/doublex/2012/07/daily_beast_and_home_birth_fear_trumps_data_in_a_new_story_on_having_babies_at_home_.html (accessed: 10 February 2020).

47 Firestone, S. (1970), *The dialectic of sex: The case for feminist revolution*, New York; Farrar, Straus, and Giroux.

48 Privett, K. (2007), Dystopic Bodies and Enslaved Motherhood, *Women: a cultural review*, 18(3), 276.

pregnancy⁴⁹, one commonality is that the maternal body is continuously subjected to control and interpretations, especially from the medical institutions.

Having a policy that bans homebirth curtails freedom because it cuts out alternatives to how pregnant individuals can perceive their bodies and role in society, the sense of pressure on pregnant citizens, their agency altogether, preventing them from having any interests of their own. Indeed, previous researchers have found that facility-based births potentially diminish self-esteem because pregnant individuals “feel that they have lost control over the most fundamental aspects of self”⁵⁰. In more recent publications, the control of pregnancy “threatens the autonomy and bodily integrity of pregnant and nursing women”⁵¹. Pregnant individuals can be forced to abide by the idealized discourse of motherhood as they affirm their new identity. In her book, *Mass Hysteria: Medicine, Culture, and Mothers’ Bodies*, Rebecca Kukla⁵² argues that from the Enlightenment period onwards, maternal bodies became a public spectacle, greatly related to the nation. Pregnant bodies were laid out for public viewing by the physicians, which developed social anxieties on motherhood in the succeeding centuries. This is evident in the procedures surrounding pregnancy, including medical research and practice, which shape how pregnant individuals understand and experience their own bodies. Kukla then introduces two types of motherhood, the “fetish mother” and “unruly mother”. The “Fetish Mother” is characterized as an ideal mother “symbolizing and creating natural order”. In contrast, the “Unruly Mother” is seen as someone deviating from the norms of motherhood and blamed for having deformed fetus and “needs to be displaced into public space so that it can be prevented from spreading hysteria and unnatural disorder”⁵³. Restricting homebirth isolates those who refuse hospital birth, who can be associated with “Unruly Mothers” that bring disorder and division.

This, in turn, supports the idea that the burden of birthplace is on the shoulders of pregnant citizens instead of the state. This type of moral takeover of the choice of birth place veers away from the idea that pregnant citizens actually pay the price of state failure to provide better birthplace alternatives. When the moral burden is attached to the pregnant person, it legitimizes the authority of the state to curtail individual’s freedom for reasons that “[t]he evil consequences of [one’s] acts do not then fall on [oneself], but on others; and society, as the protector of all its members,

49 Graham (1976).

50 Wertz, R. W. and Wertz, D. (1989), *Lying-In*, New Haven, CT; Yale University Press, 128.

51 Mahowald, M.B. (2007), Review of the book *Mass Hysteria: Medicine, Culture, and Mothers’ Bodies*. *Hypatia*, 22(3), 216.

52 Kukla, R. (2005), *Mass hysteria: Medicine, culture, and mothers’ bodies*. Lanham, Md; Rowman & Littlefield.

53 Ibid, 85.

must retaliate on [this individual]”⁵⁴. What would particularly be worrisome about seeing homebirth restriction as a moral choice of pregnant citizens is that it justifies coercion of pregnant persons, not merely in the sense of securing social benefits, but in the sense that they believe it as means of freeing themselves. The subtle coercion of homebirth restriction is not seen as coercion at all, but rather as liberation, and non-compliance to it can be seen as a reflection of a “lower” morality. However, this is not generally true for all countries that restrict homebirth, and thus “women who decide to give birth at home are behaving unethically by refusing to strap their baby in for the ride”⁵⁵.

An unguarded implementation of homebirth restriction might get the pregnant person to feel an inappropriate (or inappropriately strong or weak) emotion, attribute too much importance to the wrong things (e.g., other’s approval on one’s birthing choices), or to simply doubt one’s own moral judgment when there is no good reason to doubt at all. Berlin refers to this as a “monstrous impersonation”⁵⁶ or an act of affording those in power “to ignore the actual wishes of men or societies, to bully, oppress, torture them in the name, and on behalf, of their ‘real’ selves”. Here, the question of what makes homebirth restriction acceptable and what makes it questionable is not relevant when the issue is framed morally because the choice on birthplace is judged either good or evil.

3. *Imposing how to ascribe value to risk*—A collection of literature has been written about how health transitioned from being merely individual lifestyles and preferences to being suggestive of moral meanings⁵⁷. As such, the term health risk has been largely assumed to be negative, encouraging risk-avoidant behaviors as default response⁵⁸. What complicates the issue is the change in the politics of knowledge on birthing and the technology that comes with specializing in maternal health. Specifically, the urge to control pregnant bodies was normalized by “the consolidation of medical authority and power . . . reflected in licensure laws that increasingly marginalized those who practiced alternative forms of health care”⁵⁹. These changes are found in the increasing professionalization of medicine and obstetrics on top of seeing the

54 Mill, J. S. (1859), *On Liberty*, Chicago; Great Books, 96.

55 MIDIRS (2014) The ethics of home birth. *Essentially MIDIRS*, <https://www.midirs.org/the-ethics-of-home-birth/> (accessed: 01 February 2020).

56 Berlin (1969), 133.

57 Brandt, A.M. and Rozin, P. (eds) (1997), *Morality and health*, New York; Routledge; Paul, C. (2000), Internal and external morality of medicine: lessons from New Zealand, *The BMJ*, 320(7233), 499; Pellegrino, E. (2006), Toward a Reconstruction of Medical Morality, *The American Journal of Bioethics* 6(2), 65.

58 Lupton, D. and Tulloch, J., (2002), ‘Life would be pretty dull without risk’: voluntary risk-taking and its pleasures, *Health, risk & society*, 4 (2), 113.

59 Beckett, K. and Hoffman, B. (2005), Challenging Medicine: Law, Resistance, and the Cultural Politics of Childbirth, *Law and Society Review*, 39(1), 130.

body as a moralized entity⁶⁰, which accrued altogether even before the homebirth restriction was implemented. Needless to say, advancement in medical technology on the birthing process has incrementally bureaucratized and professionalized the process of pregnancy by establishing specialists and experts in the field of maternal health. These authorities were granted the monopoly of practicing birthing services. Moreover, while there are traditional birth attendants, they were considered unsafe and, therefore, the wrong choice⁶¹.

The question is not only about whether, in the case of home birth, the active cooperation of the pregnant individual actually constitutes voluntary acceptance of the consequent risks of homebirth. It is also about what meanings pregnant individuals associate with risks. For instance, if we are to argue about risks, it is equally arguable that crossing a river or road to medical facility puts pregnant citizens at risk and therefore, should be banned⁶². A policy that bans the act based on assuming that everyone has to avoid risks as a standard belief fails to uphold citizens' freedom because the meanings associated with risk are dynamic and complex, which can also be associated with pleasure and positiveness for people⁶³. For instance, experiential knowledge such as intuition is not a less valid source of information in relation to risk⁶⁴.

Moreover, the objectivity of risk management for mandating facility-based delivery can be rather "socially constructed, biased to certain values and politically motivated to reinforce the powerful in health care"⁶⁵. Wilkerson⁶⁶ argues that medicine is a form of "social control", wherein health care practitioners are considered experts. Likewise, there are various values associated with the birthing process that can be different from what the medical institutions impose. Advocates of alternative birth place criticize the obstetric and gynecological community for maintaining and rationalizing "dominance over the birthing process" while pathologizing the maternal body and the "natural" process of giving birth⁶⁷. Forcing a facility-based delivery has to do more with feeding certain biases than with addressing medical risks. Thus, it would

60 Valverde, M. (2008), *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925*. Toronto ON; Canadian Scholars Press.

61 Ibid.

62 MIDIRS (2014).

63 Lupton, D. and Tulloch, J. (2002), Risk is part of your life: risk epistemologies among a group of Australians, *Sociology*, 36 (2), 317; Tulloch, J. and Lupton, D. (eds.) (2003), *Risk and everyday life*, London; Sage.

64 Ibid.

65 Walsh, D. (2003), Risk management is not objective. *British Journal of Midwifery*, 11(8), 474.

66 Wilkerson, A. (1998), *Diagnosis: Difference: The Moral Authority of Medicine*, Ithaca; Cornell.

67 Block (2012), para. 2-5; Matthews and Zadak (1991), 39; Nichols, (2000).

equally be a violation of bodily integrity for a pregnant individual to be forced to deliver in a place they did not choose based on one-sided health standards.

This work argues that the choice of birthplace is one subject that, when seen as a normative choice for pregnant citizens, might further curtail their freedom. In the first place, it might be inadequate to immediately celebrate or dismiss home births as good or evil unless there is a clear sense of what kind of moral framing is taken into consideration. As Berlin argues, restrictions might lead a person to feel freer by being coerced because the state prevents self-destructive activities. However, when the restrictions of birth place are framed as helping individuals choose a “moral option” because it is in their “best interest”, it comes at the expense of seeing it as an institutional issue, that is, a failure to provide informed choice or more options for the birthing process. Again, to argue for or against homebirth restriction is one thing; to assess the framing of an argument is another. For instance, a questionable moral framing for justifying freedom restrictions is proffering the idea of “correcting” undesirable circumstances such as high-risk births, that is, having high birth order, birth intervals that are too short, and too young or too old maternal age. Public health experts emphasize that these high-risk births are “avoidable” and, by all means, should be avoided. And, it is reasonable to suggest avoiding these conditions as they are associated with vulnerability (D’ Angelo et al., 2002). However, an implicit bias takes place when, failing to avoid these risks, for example, one got pregnant too early is seen as wrong. This framing legitimizes moral foundations for imposing homebirth restriction by making pregnant persons choose the “right” option. It combats the rather harsh Malthusian⁶⁸ argument that investment among risky birth may place the society to no benefit and that ‘[a]ll children born, beyond what would be required to keep up the population to a desired level, must necessarily perish, unless room be made for them by the deaths of grown persons’⁶⁹. Given these conditions, there is a seemingly legitimate state interest in the restriction of birthing processes that not only justifies but also moralizes the exercise of police power (the limiting of individual rights) because of the existing right to life and health. Procedural matters aside, the exercise of police power restricts the freedom to protect the rights of pregnant people as lawful subjects.

Implications on Governance and Duty-bearing

The danger in seeing the choice of birth place within the frame of ‘right-wrong’ choice is that those who fail to comply with homebirth restriction might become subjects not

68 Chase, A. (1977), *The Legacy of Malthus: The Social Costs of the New Scientific Racism*, New York; Alfred Knopf.

69 Ibid, 7.

only to legal sanctions but also to moral scrutiny. But, whatever the incidental features of morally framing choice of birth place are, these have implications on projecting a pregnant person as someone who is choosing between a moral and immoral act by virtue of choosing a birth place. Framing the choice of birth place as a moral issue also invites pregnant people to doubt their own judgment, which might be morally coercive in situations where – perhaps due to intoxication or strong emotions – there are practical considerations. Here, facility-based births are generally considered far less “evil” than home-births, which can be self-destructive. A pregnant person becomes a result of a society being deeply embedded in shaping a moral outlook against the individual alone. A pregnant citizen’s choice of birth place can be a source of frustration and distress if the dominant moral act in the context of pregnancy does not approve one’s choice. Even those who have repudiated the marginalization wars may still find these influencing their thought and behavior in unwanted ways. This moral discourse to birth place brings about the sense that the morality of those who decide whether or not to have home births can be automatically judged openly. What this uncovers is the constitution of judgments about what counts as legitimate and illegitimate moral action in childbirth. This veers away from the question of the political powers at play during pregnancy and childbirth. Issues about the childbirth always involve the competence of pregnant citizens to bear a fetus, and discussions are embedded in moral judgments about pregnancy decisions that best match people’s values. Consequently, those who take homebirth restrictions as a moral issue are considered to contribute to public moral discourse. Pregnancy and childbirth, then, are used for moral talks about justice or human rights.

This work argues that to arrive at a gainful discussion on birth issues, there is a need to focus on what exactly is the function of homebirth restriction in a democratic system instead of seeing individual moral obligation as the center of the issue. The more relevant concern is whether or not homebirth restriction transgresses the autonomy of pregnant people. How this work assesses homebirth restriction’s relationship with autonomy has more to do with the norms of freedom of choice, rather than homebirth restriction being a moral choice of citizens. For instance, the principle of autonomy may find homebirth restriction harmful for democracy as it leaves little space for actual choice. A broader democratic understanding of homebirth restriction is evident in the differences in what is meant by “choice”. While developed countries advocate for home births on the basis of rights, the same democratic argument cannot be said in the poorer countries. In the developed world, arguments for home births are anchored on the concepts of empowerment, control, choice, comfort, and refusal to have technological interventions. In the poorer countries, however, most of the pregnant citizens who opt not to undergo adequate care have not necessarily refused recommendations from antenatal care providers. Instead, there are structural

constraints that have disabled them to do so. The “choice” of home birth in the developing world is very much different from the “choice” of home birth in developed countries. The developing world context of home birth is more of a function of not being able to pay, inaccessibility, and community norms⁷⁰. In other words, while refusing to have facility-based delivery means empowerment and control in other parts of the world, refusal by pregnant citizens in poorer contexts does not mean that facility-based delivery is unwanted and curtails freedom; it is more of the fact that these services are not attainable even if the pregnant persons desire them. In this sense, the homebirth restriction has both coercive and empowering character in a democratic system.

While there is wisdom behind homebirth restriction, this work argues that this is only justifiable in view of the pre-condition that the state protects its pregnant citizens and offers alternatives as it restricts liberties. Only this type of restriction allows the state’s citizens and all human beings alike to optimize the potentials of their lives⁷¹. Consequently, this means that the state, through laws and adequate social structures, should regulate the unassailable rights of human beings; in this case, the freedom of pregnant citizens. Only in this circumstance, it can be said that the state protects its pregnant citizens and is thereby justified to argue that it is in the “best interest” of the pregnant citizens. To choose a birth place with all the possible alternatives is one thing; to be coerced to choose only one type of birth place is another. The former speaks of moral duty because there is the provision of necessary and sufficient elements for “choice” to be made. The latter, however, reflects the kind of “choice” that hurts freedom because it coerces citizens to make a choice without providing appropriate options. The birthing process is a complex concept, beyond choice. It is also a consequence of various interlocking vulnerabilities such as poverty, lack of education, lack of exposure to reproductive knowledge, and poor reproductive practices⁷² and also there are indeed a plethora of reasons not to utilize adequate antenatal and delivery services. A long-standing issue has always been the inaccessibility and unavailability of health facilities and attendants⁷³.

In any case, there is no definitive answer code for all moral cases, let alone an explanation that would legitimize using moral instinct to assess moral discussions. However, it does not mean that there could be no normative task. This challenge is to understand how homebirth restriction measures up to the ethical demands of democracy. The issue of homebirth restriction is like that of giving birth, that

70 Sanfelice and Shimo (2015).

71 Locke, J. (1960), *Two Treatises of Government*, Cambridge; Cambridge University.

72 Price, N. L., and Hawkins, K. (2007), A conceptual framework for the social analysis of reproductive health, *Journal of health, population, and nutrition*, 25(1), 24.

73 Ibid.

after the water has broken, the time to decide what to do next is not that much. Given the relative controversy of the issue, the next concern is dealing with the tight knot of associations and feelings that constitute the overall expectations of pregnant citizens. There is a need to understand what makes possible the distressing cascade of moralizing ideas and feelings that are associated with pregnant citizens. And for that, it is helpful to shift from a piecemeal perspective of placing a moralizing tendency against pregnant persons.

Conclusion: The Womb as a Space of Accountability

Indeed, the choice of birthplace is a vibrant subject to political discussions. How then it can be answered if the question is what must be done. This work supposes that the answer can be found in the accountability of any policy to democratic ethics. This work settles for a simpler solution, albeit temporary: to start by not conflating the choice of pregnant citizens with their morality. Needless to say, unfolding discussions on the politics of birthplaces will not resolve which specific actions to take and the degree it has to be taken. It does not tell if an action will be the best option, and it can only suggest the possible implications of the data. What it does is merely to add confidence about the reasonableness of any given decision. However, it is still necessary to recognize the shifting lens from moral agents as choice-makers to the statutory moral obligation towards citizens, especially when making decisions that reshape the public health policy. This statutory moral obligation requires providing options instead of imposing restrictions on the birthing places, especially when it involved 'the other' or marginalized groups. Of course, policies always assume to have an ethical basis and moral arguments. However, to moralize a choice as an attack to the personal agency rather than as a critical reflection to the current state of affairs may not serve to benefit democracy.

The legitimate moral concerns for homebirth restriction do not end in the moral obligation of the state to pregnant citizens, but it is also found in the obligation to suppress the marginalization of pregnant persons. The homebirth restriction's transgressions of autonomy may result in dismay, but these may be profitable, albeit temporarily, to enrich discussions on what freedom is and its standing in a democracy for it reflects how a given health system is performing, both from the sides of the stakeholders and claim holders. It is an indicator for assessing whether general goals for the population were and are being met. While restricting homebirth does not *per se* introduce an innovative idea, it has the potential to be a space of contention to provide additional insights and more detailed examining the politics of birth. Homebirth restriction prevents, if anything, indifference and leaving the

birthing process in the margins. Hence, the homebirth restriction has the potential to break fragile situations, thereby rendering issues in sight. Homebirth restriction enters the space of personal choice, away from the impersonal approach to politics and authority, among others. This envisions pregnant citizens as capable of deciding with informed choice rather than obligatory decisions. This exposes the undiscussed premises of birth place issues, which are ‘things often left out of argumentation because they seem obvious’⁷⁴. It opens up sentiments towards pregnant citizens’ choices and links these to the dynamic of reasoning in the public sphere. As such, the homebirth restriction may serve as a space for deepening our understanding of what freedom is. It renders certain issues recognizable, thereby clarifying the scope of what counts as a choice, freedom, and moral. Homebirth restriction’s potentials are derived from its character to give disturbed taken-for-granted assumptions on freedom concerning birthplaces and hence transform these issues into political contentions rather than moralizing the choices of pregnant citizens. It can raise unspoken concerns, manifest unseen grievances, and activate a series of questions. The justifications for homebirth restriction (and traditional birth attendant) can then be lobbied more if argued in terms of rights rather than morality. This manner of looking at birth place choice can make health care investments more democratic. Given that the discussions of this work identified intersecting questionable concerns in moralizing birthplace choice, a challenge is set to determine the best way to holistically address the issues surrounding pregnant citizens without nitpicking at them.

A demographic process such as birth is especially crucial for autonomy because the body is a personal matter. Partially-guided policies may result in irreversible consequences for pregnant citizens. The discussions in this work call for a wide-ranging and interdisciplinary approach to the entire concept of the birthing process, where there are various ethical areas of discussion to unpack. What is much clearer shown, though, is the fact that the needs of the pregnant citizens are dependent upon a wide array of aspects that encompass biological, ethical, and political aspects. And finally, the discussions have shown that the choice of birth place needs to be redefined for specific vulnerable populations. Reasonable disputes on morality reflect how political agents interpret reality. It is indeed difficult to establish what things can be subjected to moral standards, let alone justify them. However, it is also more difficult to unlearn that some subjects are not necessarily to be taken in moral terms. It looks as though any attempt to ascribe moral codes to specific subjects might result in indoctrination rather than education. This is where the analysis of differences in human decisions and actions comes into play. It is done so that it can be a guide in deciding which directions and policies to take based on information on how

74 van Eemeren, F. (2001)(ed.) *Crucial Concepts in Argumentation Theory*, Amsterdam; Amsterdam University Press, 50.

different groups are. In the end, however, achieving the goal of homebirth restriction in order to foster healthy delivery among pregnant persons is just the start of the many intersecting deprivations that both the pregnant citizens and newborns from vulnerable groups have to face.

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Politika mjesta porođaja: Ispitivanje etike izbora mjesta porođaja

Sažetak

Rad ispituje etičke aspekte ograničavanja poroda kod kuće. Fokusira se na to kako ograničenje poroda kod kuće može prekršiti načelo autonomije, jer trudnice ne samo da riskiraju gubljenje kontrole nad medicinskim odlukama s kojima se suočavaju, već i autonomiju nad svojim postupcima i kontrolu nad svojim tijelom. Koristeći Berlinovu raspravu o slobodi, rad govori o prilično skrivenoj opresivnoj prirodi ograničenja poroda kod kuće koja se pojavljuje pri pomaganju trudnicama u odabiru moralne opcije prema savjetima medicinskih stručnjaka, u vidu institucijskog neuspjeha u pružanju informiranog izbora ili opcija mjesta za rađanje pod izlikom štice „najboljeg interesa“ trudnica. Tri su glavna argumenta zbog čega ograničenje poroda kod kuće može potencijalno narušiti autonomiju: (1) nametanje autoriteta u odlučivanju o pitanjima majčinog tijela; (2) nametanje standarda u majčinstvu i trudnoći; i (3) nametanje načina pripisivanja vrijednosti riziku. Ovi argumenti ističu način na koji su državne i medicinske ustanove uspostavile ovlasti u procesu porođaja kako bi opravdale ograničavanje poroda kod kuće. Kada su državne i medicinske ustanove postavljene kao moralni autoritet za mjesto porođaja, sklonostima trudnica da rađaju kod kuće pripisuju se osjećaji krivice, srama i drugih negativnih vrijednosti koje se odnose na nečiji izbor, a ne doživljava ih se kao reakciju na kvalitetu podrške trudnicama u državnim i medicinskim ustanovama. Ograničenje poroda kod kuće odražava činjenicu da odluka trudnice o mjestu rađanja nije izolirana od prava na vlastiti izbor. Doista, postoji etički interes oko ograničenja poroda kod kuće, jer ono u najboljem slučaju može biti dobronamjerno, a u najgorem slučaju diskriminatorno.

Ključne riječi: porod kod kuće, moralizacija, sloboda.